STATE OF MICHIGAN

DEPARTMENT OF CONSUMER & INDUSTRY SERVICES

OFFICE OF FINANCIAL AND INSURANCE SERVICES

Before the Commissioner

In the matter of the Doctors of Osteopathy
and Medical Doctors Provider Class Plans
Determination Report pursuant to
Public Act 350 of 1980
_____/ No. 01-096-BC

Issued and entered
This 30th day of January 2002
by Frank M. Fitzgerald
Commissioner

ORDER ISSUING DETERMINATION REPORT

I

BACKGROUND

Pursuant to Public Act 350 of 1980, as amended (Act), being MCLA 550.1101 et seq.; MSA 24.660 (101) et seq., the Commissioner of Insurance (Commissioner) issued Order No. 01-035-BC on July 30, 2001, giving notice to Blue Cross and Blue Shield of Michigan (BCBSM), and to each person who requested a copy of such notice, of his intent to make a determination with respect to the doctors of osteopathy and medical doctors provider class plans for calendar years 1998 and 1999.

II

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Based upon the foregoing considerations it is FOUND and CONCLUDED that:

1. Jurisdiction and authority over this matter are vested in the Commissioner pursuant to the Act.

2. BCBSM has complied with all applicable provisions of the Act.

3. All procedural requirements of the Act have been met.

4. The staff reviewed relevant data pertaining to the doctors of osteopathy and medical doctors provider class plans as discussed in the attached report, including written comments received during the input period on the provider class plans. The input period was designed to provide the public with an opportunity to present data, views, and arguments with respect to these provider class plans.

5. Pursuant to Section 510(2) of the Act, a copy of the determination report and this order shall be sent to the health care corporation and each person who has requested a copy of such determination by certified or registered mail.

III

ORDER

Therefore, it is ORDERED that:

1. The attached doctors of osteopathy and medical doctors provider class plans determination report shall be incorporated by reference as part of this order and shall serve as the Commissioner's determination with respect to the doctors of osteopathy and medical doctors provider class plans for the calendar years 1998 and 1999.

2. Pursuant to Section 510(2) of the Act, a copy of the Order and the determination report shall be sent to BCBSM and each person who has requested a copy of such determination by certified or registered mail.

3. Pursuant to Section 515(1) and (2), any appeal must be filed within 30 days of the date of this determination report. The request for an appeal shall identify the issue or issues involved and how the person is aggrieved.

The Commissioner retains jurisdiction of the matters contained herein and the authority to enter such further order or orders as he shall deem just, necessary and appropriate.

DOCTORS OF OSTEOPATHY

AND

MEDICAL DOCTORS

PROVIDER CLASS PLANS

DETERMINATION REPORT

for calendar years 1998 and 1999

Office of Financial and Insurance Services

State of Michigan

DOCTORS OF OSTEOPATHY AND MEDICAL DOCTORS

PROVIDER CLASS PLANS

DETERMINATION REPORT

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EXECUTIVE SUMMARY

Pursuant to Public Act 350 of 1980, this report provides a review and determination of whether the arrangements Blue Cross and Blue Shield of Michigan (BCBSM) has established with health care providers have substantially achieved the access, quality of care, and cost goals set forth in the Nonprofit Health Care Corporation Reform Act (Act) for calendar years 1998 and 1999. The statutory goals specify that these arrangements, known as provider class plans, must assure subscribers reasonable access to, and reasonable cost and quality of, health care services covered under BCBSM's certificates.

The analysis and determination of goal performance is based on BCBSM's 1998-1999 doctors of osteopathy and medical doctors provider class plans annual reports, additional data requested of BCBSM, and information on file with respect to these provider class plans. The determination report analyzes the level of achievement for each goal separately and discusses interaction and balance among the goals.

Access Goal

Achievement of the access goal requires BCBSM to be able to assure that, in any given area of the state, a BCBSM member has reasonable access to covered physician services whenever necessary. In analyzing BCBSM's performance on the access goal, consideration was given to the formal and service benefit level participation rates of both doctors of osteopathy and medical doctors in each geographic region as well as by type of specialty. BCBSM was able to maintain participation rates of over 90% on both a formal and “per case” basis during 1998 and 1999. BCBSM also significantly improved its participation rates with specialty providers, particularly anesthesiologists, in various regions around the state that previously had participation rates lower than 50%. Given that BCBSM was able to achieve overall formal and service benefit level participation rates of over 90% and improved participation rates with specialty physicians that previously had low participation rates in various regions throughout the state, it is determined that BCBSM met the access goal for both provider classes during 1998 and 1999.

Quality of Care Goal

The quality of care goal requires BCBSM to assure that providers meet and abide by reasonable standards of health care quality. To achieve this goal, BCBSM must show that it makes providers aware of practice guidelines and protocols for physician services, that it verifies that providers adhere to such guidelines and that it maintains effective methods of communication with its providers. During calendar years 1998 and 1999, BCBSM has developed initiatives to improve quality of care through demonstrated outcomes and performance standards that will be used as a basis for future quality of care measurements. In addition, BCBSM continued to monitor the effectiveness of physician utilization management and quality assessment programs and maintained communication with physicians through its monthly publications, appeal processes and provider manuals.

Therefore, it is determined that BCBSM met the statutory goal for calendar years 1998 and 1999 for both the doctors of osteopathy and medical doctors provider classes.

Cost Goal

The cost goal requires that the arrangements BCBSM maintains with each provider class will assure a rate of change in the total corporation payment per member that is not higher than the compound rate of inflation and real economic growth. Achievement of the cost goal is measured by application of the cost formula specified in the Act, which is estimated to be 4.4% for the period under review. As the rate of change in the total corporation payment per member for the doctors of osteopathy and medical doctors provider classes have been calculated to be an increase of 7.0% and 8.0%, respectively, over the two years being reviewed, BCBSM did not meet the cost goal stated in the Act for 1998 and 1999.

Overall Balance of Goals

In summary, although BCBSM did not substantially achieve one of the three statutory goals for the doctors of osteopathy and medical doctors provider class plans for the two year period under review, a change in these plans is not required because, as discussed in the body of this report, there has been competent, material, and substantial information obtained or submitted to support a determination that the failure to achieve all of the goals is reasonable, due to factors listed in Section 509(4).

Determination Report
Order No. 01-096-BC

Introduction

The purpose of this report is to determine whether Blue Cross and Blue Shield of Michigan (BCBSM) met the access, quality of care, and cost goals outlined in the Nonprofit Health Care Corporation Reform Act, MCLA 550.1101 et seq. (Act), with respect to the doctors of osteopathy and medical doctors provider class plans for the calendar years 1998 and 1999.

In addition to the final determination, this report will: define a provider class plan, explain the statutory review process, and provide a detailed summary of the data considered in reaching the determination as well as a statement of findings, which support that determination.

Provider Class Plans - Legal Background

Section 107(7) of the Act, defines a provider class plan as "a document containing a reimbursement arrangement and objectives for a provider class, and, in the case of those providers with which a health care corporation contracts, provisions that are included in that contract." Simply stated, a provider class plan is a document that includes measurable objectives for meeting the nonprofit health care corporation's access, quality of care, and cost goals outlined in the Act.

Section 504(1) of the Act requires BCBSM to contract with or enter into a reimbursement arrangement with providers in order to assure subscribers reasonable access to, and reasonable cost and quality of, health care services in accordance with the following goals:

1. BCBSM must contract with or enter into reimbursement arrangements with an appropriate number of providers throughout the state to assure the availability of certificate covered health care services to each subscriber. Section 502(1) of the Act specifically indicates that a participating contract with providers includes not only agreements in which the providers agree to participate with BCBSM for all BCBSM members being rendered care, but also agreements in which the provider agrees to participate only on a per-case basis. Participation with BCBSM means that a provider of health care services agrees to accept BCBSM's approved payment as payment in full for services provided to a BCBSM member.

2. BCBSM must establish and providers must meet and abide by reasonable standards of quality for health care services provided to members.

3. BCBSM must compensate providers in accordance with reimbursement arrangements that will assure a rate of change in the total corporation payment per member to each provider class that is not higher than the compound rate of inflation and real economic growth.

Section 509(4) of the Act requires the Commissioner of the Office of Financial and Insurance Services (Commissioner) to consider various types of information in making a determination with respect to the statutory goals. This information includes:

1. Annual reports filed by BCBSM, which pertain to each respective provider class;

2. Comments received from subscribers, providers, and provider organizations;

3. Health care legislation;

4. Demographic, epidemiological and economic trends;

5. Administrative agency or judicial actions; sudden changes in circumstances; and changes in health care benefits, practices and technology.

The Commissioner shall also assure an overall balance of the goals so that one goal is not focused on independently of the other statutory goals and so that no portion of BCBSM's fair share of reasonable costs to the provider are borne by other health care purchasers. After careful consideration of all of the information that was submitted or obtained for the record, the Commissioner must make one of the following determinations for each provider class plan pursuant to Section 510(1) of the Act:

(a) That the provider class plan achieves the goals of the corporation as provided in Section 504 of the Act.

(b) That although the provider class plan does not substantially achieve one or more of the goals of the corporation, a change in the provider class plan is not required because there has been competent, material, and substantial information obtained and submitted to support a determination that the failure to achieve one or more of the goals was reasonable due to the factors listed in Section 509(4) of the Act.

(c) That the provider class plan does not substantially achieve one or more of the goals of the corporation as provided in Section 504 of the Act.

If the Commissioner determines that the plan does not substantially achieve one or more of the goals, without a finding that such failure was reasonable, BCBSM must transmit to the Commissioner within six months a provider class plan that substantially achieves the goals, achieves the objectives, and substantially overcomes the deficiencies enumerated in the findings. If after six months or such additional time as provided for in Section 512, BCBSM has failed to submit a revised provider class plan as stated above, the Commissioner must then prepare a provider class plan for that provider class.

Overview of the Doctors of Osteopathy and Medical Doctors Provider Class Plans

The doctors of osteopathy and medical doctors provider classes cover a comprehensive range of health services including medical visits, surgery, technical surgical assistance, psychiatric care, maternity, anesthesia, consultations, diagnostic and therapeutic x-rays, physical therapy and laboratory and pathology.

For the period 1998-1999, payments to doctors of osteopathy and medical doctors

represented an average of 17.8% of the total benefit payments made to health care providers on behalf of BCBSM members. For the purpose of provider class plan reviews by the Office of Financial and Insurance Services (OFIS), paid claims data are categorized by nine geographic regions. A map, which depicts these geographic regions, is included in Attachment A.

BCBSM's only qualification standards in order for doctors of osteopathy and medical doctors to participate with and receive reimbursement from BCBSM continue to be only licensure and the signing of a BCBSM physician and professional provider participation agreement.

During the review period, reimbursement to doctors of osteopathy and medical doctors was the lesser of the provider's billed charges or the BCBSM maximum payment set forth in BCBSM's Maximum Payment Schedule. The term "billed charge" refers to the actual charge indicated on the claim form submitted by the provider. BCBSM's maximum payment is based on the Health Care Financing Administration's (HCFA) resource based relative value scale (RBRVS). RBRVS is a schedule of relative procedure values that reflect the resource cost required to perform each service. The resources used in the RBRVS structure include time and work effort, specialty training, malpractice premiums and practice overhead. Values are assigned to each service in relation to the comparative value of all other services. Multiplying the relative procedure value by a BCBSM conversion factor results in the maximum payment level. Effective April 1, 1999, BCBSM implemented the 1998 HCFA relative value units with a budget neutral conversion factor. Changes in the relative value units impact physician fees. Maximum payment levels for individual procedure codes either increased or decreased based on the new relative value units and conversion factor. The BCBSM Board of Directors reviews provider payment levels at least annually, although BCBSM does not guarantee its providers that the review process will result in increased reimbursement.

Currently, there is a single maximum payment level utilized on a statewide basis. The increases in the maximum payment levels for most procedures in 1998 and 1999 were 0.8% and 1.5%, respectively.

During the review period, doctors of osteopathy and medical doctors could participate with BCBSM either under its formal participation program or on a per-case basis. A formally participating provider has signed an agreement to accept BCBSM reimbursement as payment in full, excluding applicable co-payments or deductibles, for all covered services rendered to BCBSM members by the provider.

BCBSM is required to include as part of each provider class plan its objectives toward achieving the goals specified in the Act. BCBSM's objectives with regard to the doctors of osteopathy and medical doctors provider class plans are as follows:

Access:

- To ensure adequate availability of the high quality medical services, throughout the state, at a reasonable cost to BCBSM subscribers.

- Maintain a reimbursement methodology in conjunction with the Physician and Professional Provider Participation Agreement that is based on the lesser of the billed charges or BCBSM's maximum payment schedule.

- BCBSM will review reimbursement levels at least every 12 months.
  An alternative reimbursement is available to groups through the Medical Surgical (MS-90) program. The MS-90 program was designed to increase reimbursement levels for purposes of reducing out of pocket payments in regions where participation rates are low.

- Adjust maximum payment levels for key specialties with low access.
  Physicians who provide anesthesia services will be paid according to the RBRVS method for anesthesia services. A BCBSM-specific conversion factor that is based on geographic region will be used so that participation rates for these physicians in West Michigan will not be jeopardized.

- Maintain and periodically update the directory of participation physicians and professional providers.

- Maintain and update, as necessary, in the Physician's Manual a "Providers' Bill of Rights" explaining: (1) a provider's right to a managerial level conference under P.A. 350; (2) how the managerial level conference process works and the timeframes involved under it; (3) when the P.A. 350 process can be invoked; (4) how this process relates to the other processes described in the contract. This communication will emphasize that a managerial level conference is a right guaranteed by law to every provider and that arbitration is an alternative to this right.

Quality of Care:

- To ensure provision of quality care to BCBSM subscribers through the application of participation qualifications and performance standards as a basis for physician participation.

- The Physician and Professional Provider Contract Advisory Committee meets on an ongoing basis, generally at least quarterly, to offer advice and consultation on topics such as: proposed modifications to the contract; administrative issues which may arise under the contract; medical necessity criteria and guidelines; reimbursement issues; experimental or investigational procedures; and physician supervision of services.

- Work with the Physician and Professional Provider Contract Advisory Committee to review and update medical necessity criteria, as necessary.

- The Physician's Manual is maintained and updated, as necessary, to explain billing, benefits, provider appeals processes, managed care, BCBSM's record keeping requirements and an explanation of the Physician and Professional Provider Participation Agreement and its administration.

- Protocols and procedures relating to the BCBSM's Physician Retrospective Profiling Program are communicated to providers as they become available.

Cost:

- To strive toward limiting the increase in the total physician payments per member to the compound rate of inflation and real economic growth as specified in Public Act 350, giving special consideration to Michigan and national health care market conditions.

- To provide equitable reimbursement to physicians in return for high quality services which are medically necessary and delivered to Blue Cross and Blue Shield of Michigan (BCBSM) subscribers at a reasonable cost.

- Each year retrospective profiles are made available to providers upon request.

- BCBSM makes a good faith effort to enforce the per case participation rule in Section 502(1)(b) of P. A. 350 through its audit activities, its provider inquiry and provider consultant activities, and through responses to all complaints. BCBSM will annually report its efforts to enforce the rule and identify any violations that have occurred.

History of the Doctors of Osteopathy and Medical Doctors Provider Class Plans

BCBSM had an existing reimbursement arrangement with both doctors of osteopathy and medical doctors when the Act took effect on August 27, 1985. BCBSM first filed the doctors of osteopathy and medical doctors provider class plans with OFIS pursuant to Section 506(1) of the Act on May 11, 1987. Section 506(2) states:

"Upon receipt of a provider class plan, the commissioner shall examine the plan and shall determine only if the plan contains a reimbursement arrangement and objectives for each goal provided in Section 504, and, for those providers with which a health care corporation contracts, provisions that are included in that contract."
Section 506(2) further states:

"For purposes of making the determination required by this subsection only, the commissioner shall liberally construe the items contained in a provider class plan."

Since the doctors of osteopathy and medical doctors provider class plans met the filing requirements of Section 506 of the Act stated above, OFIS notified BCBSM by letter on May 27, 1987 that the doctors of osteopathy and medical doctors provider class plans were placed

into effect and retained for the commissioner's records pursuant to Section 506(4).

On November 5, 1987, BCBSM amended all of its provider class plans, including the doctors of osteopathy and medical doctors plans, to include an appeal process for utilization review audits performed by the corporation. This amendment to the doctors of osteopathy and medical doctors provider class plans was made by BCBSM in accordance with Section 508(1) of the Act.

The doctors of osteopathy and medical doctors provider class plans were modified by BCBSM on August 20, 1990, August 2, 1991, August 30, 1994, February 27, 1995, August 1, 1995 and December 30, 1996 and October 31, 1997. BCBSM made various changes to the plan, including the implementation of a new participation agreement and reimbursement methodology, a revision in the definition of medical necessity, changes to the participation agreement due to BCBSM's participation in the Inter-plan Teleprocessing System and the disclosure requirements of the Blue Cross Blue Shield Association, a change in the provider appeal process, changes to the initiatives and objectives of both plans, and changes pertinent a pilot program in western Michigan for anesthesia providers and the direct reimbursement of certified registered nurse anesthetists.

Review Process

On July 30, 2001, the Commissioner issued Order No. 01-035-BC, which provided written notice to BCBSM, health care providers, and other interested parties of his intent to make a determination with respect to the doctors of osteopathy and medical doctors provider class plans for the calendar years 1998 and 1999. Section 505(2) requires the Commissioner to establish and implement procedures whereby any person may offer advice and consultation on the development, modification, implementation, or review of a provider class plan. Thus, Order No. 01-035-BC also called for any person with comments on matters concerning these provider class plans to submit written comments to OFIS in accordance with Section 505(2) of the Act by November 30, 2001.

Summary of Advice and Consultation:

The only comments received during the input period on the doctors of osteopathy and medical doctor provider class plans were filed on behalf of the Michigan Optometric Association (MOA). The following is a summary of MOA's comments:

> The MOA contends that BCBSM purposely limits the participation of optometrists to the vision program services included in its vision specialist provider class plan. Professional services covered under the vision program are limited to providing eye examinations for the purpose of determining the need for glasses and contact lenses. Vision program services do not include medical services even though optometrists are defined in the Public Health Code as physicians. BCBSM refuses to pay optometric physicians for any CPT codes recognized by the American Medical Association, even though optometrists have had the ability to use diagnostic pharmaceutical procedures and agents to diagnose diseases of the eye

since 1984. Further, legislation passed in 1994 expanded the optometric scope of practice to allow optometrists to prescribe therapeutic pharmaceutical agents in order to treat or manage a medical condition that the optometrist diagnosed.

Yet, even though BCBSM pays ophthalmologists for evaluation and management codes relating to the diagnoses and treatment of the eye, BCBSM refuses to pay optometrists for the same procedures and evaluation and management codes on the basis that optometrists may not receive reimbursement for medical services and procedures because such services are not included in BCBSM's vision certificates or the vision specialists provider class plan. This policy is contrary to Attorney General Opinion 6410 that makes clear that BCBSM cannot discriminate against classes of physicians. MOA contends that MCL 550.53(7) and MCL 550.1502a(11) also prohibit such discrimination. A court ruling held that "the scope of optometry includes the diagnosis of eye disease [and] the Court is of the opinion that optometrists were wrongly excluded from medical provider panels in violation of § 502a", which means that optometrists were able to diagnose diseases of the eye. These services are performed and reimbursed by almost every major insurer in the state as well as Medicare and Medicaid. BCBSM's refusal to reimburse the patient or the optometrist for such services not only discriminates against a particular provider class, it also denies fair and appropriate access to services that optometrists can legally provide to their patients. This is particularly of importance in certain rural areas in northern Michigan that do not have ophthalmologists readily available. MOA contends that optometric services are more widely utilized than ophthalmology for routine ocular care and believes that such services are more cost effective. MOA included with its comments its proposal that a separate provider class plan be created for optometrists or alternatively, that optometrists be incorporated into the doctors of osteopathy and medical doctors provider class plans in order for optometrists to be reimbursed for certain medical procedures that BCBSM currently does not pay for under the terms of the vision specialists provider class plan.

A response to MOA's concerns was filed by BCBSM in January 2002. BCBSM summarized the legal proceedings from MOA's current litigation regarding the above noted reimbursement issues filed against the Commissioner in the Ingham County Circuit Court (Michigan Optometric Association v. Frank M. Fitzgerald, File No. 99-90816-CK). The circuit court ruled partially in favor of MOA's position in the matter. The matter is currently on appeal to the Michigan Court of Appeals. BCBSM states that while it does not agree with the circuit court's ruling in favor of MOA, it has nonetheless begun working with MOA to determine if the issues raised in the lawsuit can be resolved. If BCBSM ultimately decides to reimburse optometrists for the medical procedures they are permitted under their licensing statute to perform, BCBSM requests that OFIS not consider MOA's proposals until a final determination is made that BCBSM will, or must, pay optometrists for these services. BCBSM does not believe that any changes should be made to the doctors of osteopathy or medical doctors provider class plans. Most physicians covered under the doctors of osteopathy and medical doctors provider class plans are trained to render services that are unrelated to the treatment of the eye. Optometrists, on the other hand, provide only a limited number of medical services related

solely to the treatment of the eye. Optometrists therefore do not naturally fit under these physician provider classes. BCBSM believes that the objectives of MOA can best be met by revising the vision specialists provider class plan to allow them to bill for certain medical procedures. The revisions would be minor and would keep optometrists under one plan, which would make it easier for customer groups and OFIS to review their performance.

Discussion of Goals Achievement/Findings and Conclusions

Access Goal:

The access goal in Section 504(1) of the Act states that "[T]here will be an appropriate number of providers throughout this state to assure the availability of certificate-covered health care services to each subscriber."

In order to achieve compliance with the access goal, BCBSM needs to be able to assure, that in any given area of the state, a BCBSM member has reasonable access to physician services covered under the terms of that member's medical-surgical certificate whenever such treatment is required. In analyzing BCBSM's performance on the access goal, OFIS staff examined several aspects of how access to physician services could be obtained, including the formal and service benefit level participation rates of providers, to get an overall picture of how well BCBSM was assuring the availability of certificate-covered health care services to each member throughout the state.

The formal participation rates of doctors of osteopathy and medical doctors for calendar years 1998 and 1999 are presented below.

Formal Participation Rates by Geographic Region

	Doctors of Osteopathy			Medical Doctors		
	1998	1999	Increase (%)	1998	1999	Increase (%)
Region 1	94.7%	95.6%	1.0%	96.2%	97.0%	0.8%
Region 2	92.1	93.5	1.5	96.2	96.0	(0.2)
Region 3	96.2	96.8	0.6	91.5	92.3	0.9
Region 4	90.0	91.1	1.2	94.7	93.6	(1.2)
Region 5	89.2	90.6	1.6	90.3	93.8	3.9
Region 6	83.7	87.4	4.4	89.7	93.4	4.1
Region 7	94.8	95.4	0.6	97.8	98.4	0.6
Region 8	95.1	94.5	(0.6)	97.1	96.0	(1.1)
Region 9	94.5	96.5	2.1	98.1	98.5	0.4
Statewide	92.7%	93.9%	1.3%	94.6%	95.6%	1.1%

BCBSM states that it achieved an average 93.3% and 95.1% formal participation rate among doctors of osteopathy and medical doctors, respectively, during the two-year period under review. BCBSM experienced an overall average increase of 1.2% in the participation rates of both provider classes from 1998 to 1999.

Traditionally, doctors of osteopathy place special emphasis on the interrelationship of the musculoskeletal system to other body systems. Medical doctors, on the other hand, emphasize diagnosis, treatment of disease and other physical or mental conditions with therapeutics in which diseases and other conditions are treated by producing a condition incompatible with or antagonistic to the condition to be cured or alleviated. Yet, over the last ten to fifteen years, the distinctions between both physician types have blurred with doctors of osteopathy and allopathic physicians now practicing along side each other in hospital based systems. Because of this, when looking at BCBSM's formal participation rates by provider specialty, it makes sense to look at participation rates by physician specialty on a combined basis.

The combined 1999 formal participation rates by specialty type, by region, are shown in Exhibit A. The data Illustrate that over 95% of physicians who provide primary care services (e.g. general practice, family practice, internal medicine and pediatrics) formally participate with BCBSM. This is an important consideration in assessing access to care for both physician classes as these primary care physicians typically provide most of the health care services received by patients and/or direct the manner in which patients receive specialty care services through the referral patterns they have established within the physician community.

It should be noted that during the review of the doctors of osteopathy and medical doctors provider class plans for calendar years 1992 to 1993, the Commissioner encouraged BCBSM to work to improve access to formally participating specialty physicians in the areas of allergy, anesthesiology, otorhinolaryngology, neurosurgery, ophthalmology, orthopedic surgery, plastic surgery and urology as these eight specialties had participation rates of less than 50% in one or more geographic regions. The data in Exhibit A reveal that BCBSM has considerably improved its participation rates for these specialties.

BCBSM states that it has worked diligently to improve its formal participation rates with anesthesiologists, particularly in western Michigan. BCBSM first implemented a pilot program in west Michigan in September 1995 that incorporated a fixed fee reimbursement methodology for anesthesia services. The pilot program was discontinued in April 1998 when a new reimbursement methodology for all anesthesia services was implemented along with direct reimbursement for certified registered nurse anesthetists. The new reimbursement for anesthesia services includes a BCBSM specific conversion factor based on geographic region. The rate differential in West Michigan versus the remainder of the state is 12 percent.

Another way to assess the availability of doctors of osteopathy and medical doctors is by looking at BCBSM's per-case participation rates. BCBSM utilizes "service benefit level rates" as a means to measure financial access because it shows what proportion of certificate covered health services were made available to members without them incurring any out-of-pocket expense. The phrase "service benefit level rate" refers to the percentage of services paid to providers participating with BCBSM on either a formal or per-case basis who accepted BCBSM payment as payment in full. The service benefit level rates for doctors of osteopathy and medical doctors for 1999 are illustrated below. The data shows that physicians generally accepted BCBSM reimbursement for at least nine out of every ten services rendered to BCBSM members throughout 1999.

Doctors of Osteopathy and Medical Doctors
Service Benefit Level Rates - 1999

Region	Services Paid In Full	Total Services	% Paid In Full
1	4,371,934	4,474,708	97.7%
2	420,508	436,369	96.4%
3	786,322	791,693	99.3%
4	481,769	493,263	97.7%
5	776,596	818,952	94.8%
6	936,052	1,001,208	93.5%
7	691,711	706,039	98.0%
8	433,525	447,407	96.9%
9	199,812	200,339	99.7%
Statewide	9,098,229	9,369,978	97.1%

It should be noted that during the review of the doctors of osteopathy and medical doctors provider class plans for calendar years 1992 to 1993, providers expressed concern regarding BCBSM's reimbursement policies pertaining to services rendered by physician assistants. They believed that BCBSM's restrictive policies limited a BCBSM member's access to care. At that time, BCBSM had agreed to reexamine its definition of supervision with respect to physician assistants. BCBSM, with assistance from the Michigan Academy of Physician Assistants, implemented new supervision requirements for physician assistants on May 1, 2000. The physician still needs to be available for direct and continuous communication in person or by telephone and must continue to review and sign the patient records, but the services no longer must be provided under the direct and personal supervision of a physician. BCBSM has a few additional supervision requirements for physician assistants who practice in rural or underserved areas, but overall BCBSM's new supervision requirements for physician assistants clearly are designed to increase access to medical services.

BCBSM encourages its members to confirm the participation status of their physician before they receive services, particularly if their regular physician refers them for specialty care. Although provider directories were updated and published in fourth quarter 1998, BCBSM members can obtain current participating physician information by calling BCBSM's toll-free customer service number. Current participating physician information is now available on BCBSM's website at www.bcbsm.com. BCBSM notes that its website directory is updated on a weekly basis and thus provides a great resource to BCBSM members seeking out physician and professional providers.

The Michigan Optometric Association (MOA) has expressed concern over its members' inability to be reimbursed by BCBSM for medical services pertaining to the diagnoses and treatment of the eye. MOA contends that because the scope of practice guidelines for optometrists have been expanded to allow optometrists to diagnose and treat certain eye conditions, these providers should be designated as physicians by BCBSM and should be

permitted to bill CPT evaluation and management codes in the same manner as ophthalmologists. MOA claims that there are not a sufficient number of ophthalmologists in northern Michigan to serve the population, thereby creating an access to care problem for BCBSM members. This access problem could be alleviated if BCBSM would reimburse optometrists for the services that are within the scope of their license.

Review of BCBSM data on the number of ophthalmologists and the number of participating ophthalmologists, by region, for calendar 1999 is shown below.

Ophthalmologists - 1999

Region	Participating Providers	Total Number of Providers	Participation Rates
1	281	308	91.2%
2	38	61	62.3%
3	22	25	88.0%
4	18	21	85.7%
5	56	57	98.2%
6	41	51	80.4%
7	30	32	93.8%
8	21	23	91.3%
9	11	12	91.7%
Total	518	590	87.8%

Although it might seem like the above numbers illustrate that there is an ample number of ophthalmologists in each region to serve BCBSM members, the overall totals by region are somewhat deceiving. An analysis of the same data broken down by county reveals that there actually are no ophthalmologists practicing in 35 of Michigan's 83 counties. While the majority of those counties are in the northern part of the Lower Peninsula or in the Upper Peninsula, even a few counties in mid-Michigan, such as Ionia, Hillsdale, Clinton and Eaton counties, have no ophthalmologists practicing within their boundaries. The lack of available ophthalmologists in so many Michigan counties certainly seems to support MOA's contention that access to ophthalmologists in those areas is restricted, however access to care is lacking due to the location of the ophthalmologists' practices rather than BCBSM's inability to obtain contracts with such providers. Moreover, it is important to recognize that some ophthalmologists associated with hospital based systems actually travel weekly to underserved counties, such as Ionia County, to provide services to patients needing ophthalmologic care. Also, some of the services that an optometrist is now legally able to provide to patients under the provisions of MCL 333.17401 et seq. may also be obtained from other physicians, urgent care centers and if necessary, the nearest emergency room in these regions. Inasmuch as OFIS did not receive any comments during the review of these provider class plans from BCBSM members indicating that they had experienced difficulty in being treated for medical conditions of the eye or had suffered harm as a result of so few ophthalmologists being available in a particular geographic region, it is not possible to draw

the conclusion that access to care by BCBSM members for medical conditions of the eye is not met.

We acknowledge the concerns raised by the MOA regarding the rights of optometrists to be paid by BCBSM for medical services that they are able to provide within the scope of their license and recognize that the ability of optometrists to provide and be reimbursed for such services may enhance access to care for some BCBSM members with certain eye conditions. We further recognize the recent court ruling and ongoing litigation pertaining to these issues and are aware that most other health carriers are paying optometrists for these services even though governing legislation provides exclusionary language similar to that found in MCL 550.1502(9).

However, these findings have no real relevance to either the doctors of osteopathy and medical doctors provider class plans. The statutory provisions included in the section of the Public Health Code governing optometry make clear that there is a distinction between a "physician" and an optometrist. MCL 333.17401(1)(g) indicates, in part, that the term "physician" means "a physician as defined in section 17001 or 17501." Sections 17001 and 17501 are provisions governing the licensure and scope of practice of medical doctors and doctors of osteopathy, respectively. Section 333.17001(1)(c) states, in part, that a "Physician" means an individual licensed under this article to engage in the practice of medicine. Section 333.17501(1)(b) states, in part, that a "Physician" means an individual licensed under this article to engage in the practice of osteopathic medicine and surgery. Optometrists are not defined as physicians in the Public Health Code, but rather as "licensees."

In addition, the majority of services provided by physicians under the doctors of osteopathy and medical doctors provider class plans pertain to medical services unrelated to the treatment of the eye. Most of the physicians included in these two provider classes provide either primary care services or specialize in a medical service (e.g. cardiology, orthopedic surgery) that is covered under BCBSM's medical-surgical certificates of coverage. With the exception of the limited number of medical services that an optometrist legally provides specifically related to the treatment of the eye, the majority of the services an optometrist provides are not covered under BCBSM's medical-surgical certificates, but rather are covered under BCBSM's vision certificates of coverage. As such, it would not really be appropriate for optometrists to be included in these physician related provider classes. It appears that the interests of the optometrists could best be served by modifying the vision specialists provider class plan to allow them to bill and receive reimbursement for certain eye related medical services. BCBSM is encouraged to continue working diligently with MOA to resolve this matter. The Commissioner anticipates that BCBSM will resolve this matter promptly and make the necessary modifications to the vision specialists provider class plan so that the Commissioner may review these changes during the next review of the vision specialists provider class plan. OFIS has tentatively scheduled the review of the vision specialists provider class plan for July 2002. This should allow ample time for BCBSM and the MOA to resolve their concerns and for BCBSM to modify and file a revised vision specialists provider class plan with OFIS. BCBSM is also expected to make the necessary changes to its claims processing systems and begin processing claims from optometrists for medical procedures

related to the treatment of the eye prior to the beginning of the review of the vision specialists provider class plan.

Findings and Conclusions - Access

In order to achieve compliance with the access goal, BCBSM needs to be able to assure that in any given area of the state a member has reasonable access to certificate-covered physician services, whenever such services are required. Based on the information analyzed during this review, BCBSM was able to maintain participation rates over 90%, on both a formal and "per case" basis, with both doctors of osteopathy and medical doctors during the two year period under review. BCBSM was also able to significantly improve participation rates with specialty providers, particularly anesthesiologists, in various regions around the state that previously had participation rates lower than 50%. Moreover, BCBSM participates with more than 87% of the ophthalmologists in the state. It is therefore determined that BCBSM met the access goal stated in the Act for calendar years 1998 and 1999 for both the doctors of osteopathy and medical doctors provider class plans.

Quality of Care Goal:

The quality of care goal in Section 504(1) of the Act states that "[P]roviders will meet and abide by reasonable standards of health care quality."

In analyzing BCBSM's performance on the quality of care goal, OFIS staff examined BCBSM's achievement of its quality of care objective, the methods BCBSM utilized in establishing and maintaining appropriate standards of health care quality, and BCBSM's methods of communication with medical doctors. We reviewed these factors to assure that BCBSM not only encouraged provider compliance with the expected standards of physician services, but also that it kept abreast of new technological advances available to treat those BCBSM members that require such services. All of the above factors impact the quality of medical services delivered to BCBSM members. The pertinent issues that were considered in reaching a determination with respect to the quality of care goal, based on the review of data provided by BCBSM and other sources during this review period, are described below.

BCBSM continues to take a twofold approach to achieving its quality of care objectives for the doctors of osteopathy and medical doctors provider classes. First, BCBSM attempts to promote the quality of health care delivered by providers through the enforcement of provider qualifications and utilization review programs. Second, BCBSM strives to forge strong relationships with participating providers by designing programs directed toward effective servicing and communication.

To ensure acceptable levels of care provided by both physician classes, BCBSM requires that these providers meet the participation qualifications and performance standards listed on page 3 of this report. BCBSM states physicians must be licensed by the state of Michigan and practice in Michigan. BCBSM ensures that physician licenses are current through application of an automated licensing verification system that is linked directly to the Bureau of Health Services within the Michigan Department of Consumer and Industry Services. The Bureau sends an electronic data transfer that is run, at least weekly, against the BCBSM provider database to ensure that BCBSM participating physicians retain their licenses to legally practice medicine. BCBSM inactivates the provider identification numbers (PINs) of

those physicians having had their licenses suspended, revoked or were for other various reasons ineligible to practice medicine to prevent any further claims being paid to these providers. Physicians receive written notification from BCBSM that their PINs were deactivated. BCBSM deactivated the PINs of 673 doctors of osteopathy and 2,904 medical doctors during the two-year period under review. BCBSM states that its Corporate and Financial Investigations (CFI) department also participated in the physician credentialing process by making recommendations regarding the background and credibility of various participating providers.

BCBSM uses various performance standards to measure how physicians rendered health care, taking into account such factors as medical necessity, appropriate utilization and benefit compliance. Routine assurances of quality care were tracked through utilization audits, referral to prepayment utilization review (PPUR) programs, and when necessary, intervention by its CFI department.

BCBSM performs medical record review audits of physicians in order to evaluate medical necessity and the quality of care provided to BCBSM members. BCBSM reviews records to ensure compliance with documentation guidelines that were originally developed by physicians with input from provider specialty associations. BCBSM states that its guidelines require providers to maintain a high standard of record keeping to help BCBSM ensure that quality services are provided and that the treatments and procedures billed by physicians were actually performed, that the services are proper, reasonable and necessary and were within BCBSM's benefit specifications.

BCBSM reviews paid claims and corresponding medical records to ensure that the services were accurately billed and paid and the setting was appropriate. An audit may be initiated if a provider's practice patterns change (i.e. increase in utilization) or if a provider's practice patterns differ significantly from the norm. Audit candidates may also be chosen randomly or based on studies of special procedures. BCBSM has four basic audit types, those being benefit specific, exploratory, follow-up and patient inquiry audits. A benefit specific audit is a review of all records on specific procedure codes. An exploratory audit is a review of a sample of patient records to monitor a provider's compliance with BCBSM's policies and procedures. A follow-up audit is a review of a sample or all patient records to determine whether the provider implemented BCBSM's previous recommendations. Lastly, an audit may be initiated by BCBSM with respect to a specific patient following an inquiry from the patient or a contract holder.

BCBSM substantially increased its audit activity during 1998 and 1999. The following table summarizes BCBSM's 1998-1999 quality assurance activity for both physician classes during the two-year period under review.

Year	Physician Class	# of Audits	Referred to CFI	PPUR	MLC	Identified Savings	Recoveries 1999	Audit Cases Appealed to OFIS
1998	D.O.	14	0	5	5	$110,120	-	0
1998	M.D.	83	1	16	31	$870,734	-	10
1999	D.O.	29	1	0	24	$654,837	$251,803	3
1999	M.D.	103	11	5	57	$5,521,138	$1,554,620	12
Total		229	13	242	117	$7,156,829	$1,806,423	25

BCBSM increased its audit activity of physicians during the 1998-1999 reporting period compared to previous reporting periods. BCBSM states that most physician audit appeals were resolved at BCBSM's managerial conference. BCBSM has changed the way it reports audit cases. Through 1998, BCBSM annually reported the audits that were closed or settled in that year. Starting in 1999, BCBSM began reporting the number of initial audit letters that are generated during the year to providers and any audit activities pertaining to those appeals that occurred within that year. BCBSM reports that the above 1998 data reflects the number of managerial level conferences (MLC) held and closed during that year. The number of audits indicated above for 1999 represents the actual number of audits that were initiated and closed during 1999. The number does not include a carryover of audits that were initiated in 1998 but closed in 1999. BCBSM states that managerial level conferences were requested in 1998 for 5 audits of doctors of osteopathy and 31 audits of medical doctors. In 1999, managerial level conferences were requested on 24 audits of doctors of osteopathy and 57 audits of medical doctors. BCBSM states that from 1998 to now, 5 audits have gone to binding arbitration. Three of the audit cases stem from audits conducted during the two-year period under review. All of those cases are still pending. Twenty-five of the audit cases conducted by BCBSM during the reporting period were appealed to OFIS for review and determination.

BCBSM maintained 26 physicians on its Prepayment Utilization Review Program (PPUR) during the two-year reporting period. The PPUR program is a separate claims processing system for physicians identified as having variant billing and utilization patterns. Through PPUR, BCBSM reviews medical documentation prior to payment on any billed service rendered by providers in the program. In 1999, BCBSM implemented a process for changing the program's effectiveness. System changes for the program resulted in increased claims processing efficacy that should allow for a higher volume of claims to be reviewed through the program. BCBSM states that processes to formally evaluate the program, educate providers, and modify the policies for adding providers to the program are targeted for implementation in 2000.

Another key program BCBSM has in place to monitor physician utilization patterns is the Physician Retrospective Profiling (PRP) Program. The program was implemented in 1989 and is considered by BCBSM to be an important utilization management tool under BCBSM's Physician and Professional Participation Agreement. This program compares the utilization patterns of physicians with a peer group composed of physicians belonging to the same

specialty and practicing in the same geographic region.

Changes to the PRP program came about in 1998. Physicians were involved in the program revisions through BCBSM's Physician and Professional Provider Contract Advisory Committee (PPPCAC). A subgroup formed by the PPPCAC focused on investigating new tools and methodologies to increase the value of the retrospective profile beyond an internal utilization profile. The focus was on drafting a physician profile that would become a source of information for both BCBSM and physicians. Risk adjustment and best-in-class methodologies were being examined in hopes of creating a more meaningful profile. BCBSM states that 38 physicians requested their profiles from BCBSM in 1998, with 240 physicians requesting their profiles in 1999.

During the 1998-1999 reporting period, BCBSM identified several key initiatives to guide the corporation in enhancing the quality of care rendered to its members. These initiatives included:

- Improving the effectiveness and expanding the scope of professional utilization review audits
- Expanding the prepayment utilization review program
- An expansion of focused procedures
- Improving quality and use through best practice
- Developing pharmacy initiatives
- Developing coding accuracy initiatives

BCBSM states that progress in meeting the above initiatives was accompanied by the 1999 commissioning of the Dartmouth Atlas of Health Care in Michigan. BCBSM hired a consultant to study, analyze and issue findings relative to its cost and use data, which in turn, created an opportunity to have a statewide discussion about the quality of health care. The goal was to encourage the delivery of useful care, such as the use of beta-blockers after heart attacks, while discouraging care that isn't effective. The atlas findings are based on BCBSM claims data and are shared with communities throughout the state in hopes of developing a better understanding of variation in the use of health care services and working with communities to enhance the quality of health care. The Michigan State Medical Society, Michigan Osteopathic Association and the Michigan Health and Hospital Association supported the project and participated in its development.

During the 1998-1999 reporting period, BCBSM's major focus was to improve the quality of health care services delivered to its members. In support of the *Healthy People* report developed by the U.S. Department of Health and Human Services, BCBSM developed measurable objectives of its own for improving health outcomes. Outcomes for such health care topics as domestic violence, mental health, tobacco cessation, and unintentional injuries improved in 1999. In Michigan, as well as nationwide, work still needs to be done toward reducing the number of overweight individuals and increasing all individuals' physical activity levels. BCBSM's strategy for seeking improvements has been based on a combination of educational provider seminars, member education, and the availability of discount programs. One discount program available to members is BlueSafe, which provides members with

discounts on items such as bicycle helmets, padding, life vests, and trigger locks. Another program allows discounts at Weight Watchers and on certain durable medical equipment supplies such as blood pressure kits, diabetes supplies, and first aid kits. Another program provides discounts on acupuncture, nutritional counseling, vitamins and herbs and massage therapy. Finally, a discount program that is available to Farm Bureau, group conversion and Medigap members enables them to receive discounts on prescription drugs.

In order for physicians to achieve consistently high quality outcomes while keeping cost increases under control, medical management is required. Medical management centers on the identification of "best practices" for the treatment and management of prevalent, high cost diseases. The modern use of clinical pathways is based upon ever-expanding volumes of clinical outcomes data, which tend to grow in statistical significance as more and more data is compiled. BCBSM believes that physicians and other providers are responsive to this type of data and often improve their own clinical practice patterns accordingly.

BCBSM states that using 1999 administrative claims data, BCBSM analyzed the use of medications recommended by nationally accepted clinical guidelines in the treatment of heart failure and asthma. These analyses revealed that both angiotensin converting enzyme (ACE) inhibitor therapy for the treatment of heart failure and medications recommended for long-term control of persistent asthma appear to be underutilized.

BCBSM also used 1999 administrative claims data to analyze the medical management of members with diabetes mellitus. Long-term prospective studies have shown that improved glucose control reduces the risk and slows the progression of diabetes-related complications. BCBSM supported the American Diabetes Association recommendation for glycosolated hemoglobin therapy testing twice yearly for diabetics and quarterly testing in patients whose therapy has changed or who are not meeting glycemic control goals. Other types of testing are recommended to monitor diabetic patients for cardiovascular and kidney disease. BCBSM encouraged physicians to conduct more testing of this nature to enhance members' quality of care and prevent the progression of disease states.

Another measure of BCBSM's achievement of the quality of care goal includes BCBSM's ability to effectively communicate with providers. Given that the quality of care goal defined in the Act requires that "providers meet and abide by reasonable standards of health care quality," it is necessary for providers to be made aware of BCBSM's standards, for BCBSM to verify that its providers adhere to such standards and that BCBSM is responsive to provider inquiries, input, and appeals, as all of these factors impact the quality of physician services given to BCBSM members.

During the two-year reporting period, BCBSM maintained open lines of communication by creating forums for provider input. Issues and discussions were held with the Michigan State Medical Society, the Michigan Osteopathic Association and various specialty liaison societies. BCBSM states during 1998 and 1999, it met with the Michigan Society of Anesthesiologists, Michigan Dermatological Society, the Michigan Chapter of the American Association of Clinical Endocrinologists, Michigan College of Emergency Physicians, Michigan Academy of Family Physicians, and the Michigan Society of General Surgeons,

Michigan Society of Hematology and Oncology, Michigan Society of Internal Medicine, Michigan Society of Pathologists, Michigan Radiological Society and the Michigan Section of the American College of Obstetricians and Gynecologists. In these meetings, BCBSM and physicians focused on issues, shared ideas, engaged in open discussion and identified areas of agreement and disagreement.

In addition, BCBSM's Physician and Professional Provider Contract Advisory Committee (PPPCAC) met quarterly in 1998 and 1999. The PPPCAC was established in 1990 and is actually made up of 2 committees – one for doctors of osteopathy and medical doctors and one for podiatrists, chiropractors and fully licensed psychologists. The doctors of osteopathy/medical doctor committee consists of 4 doctors of osteopathy and 5 medical doctors. The committee played a key role in supporting BCBSM's goal to actively and effectively collaborate with physicians. Topics for discussion included the annual physician fee update process, the development and discussion of provider use and pharmacy management strategies and initiatives, BCBSM's intent to collaborate with the medical community to address social health issues and determine best practices, administrative issues, legislative issues, provider profiling issues, and updates and statuses of ongoing provider affiliation strategy. BCBSM states that the ongoing issue involving the optometrists was never discussed at any meetings of the PPPCAC during the two-year period under review. BCBSM's liaison committee has already met, however, with the MOA to begin trying to resolve the reimbursement issues included in the recent circuit court ruling.

BCBSM also maintains open communications with physicians through its monthly publications, its formal appeal process and provider manuals. All participating physicians receive BCBSM's monthly publications of *The Record* and *Physician Update*. These publications contain current information relating to billing, benefit changes and medical criteria modifications. BCBSM states that the issues discussed in this publication are those that often impact physicians' practice patterns and the achievement of utilization performance standards. BCBSM's Physician's Ombudsman's office and BCBSM's Provider Inquiry departments were also available to offer individual, customized information and consultation. BCBSM offered continuing medical education seminars on recent medical topics such as antibiotic resistance, mental health, and pediatric asthma. Physicians were also encouraged to access BCBSM's website to obtain information regarding continuing medical education registration, billing seminars, tips of filing claims and links to other pertinent informational sources.

As part of the review process, OFIS examined a copy of BCBSM's physician provider manual. The current basic provider manual, last issued in August 1997, is entitled the *Guide for Physicians and Medical Assistants (Guide).* The *Guide* includes information pertaining to physician services, such as program requirements, patient eligibility requirements, benefits and exclusions, criteria and guidelines for services, documentation guidelines, claim submission information, including information on per-claim participation, and sections describing how to obtain information from BCBSM's provider inquiry department and claims appeals processes. BCBSM has not recently updated the information in the *Guide,* but rather informs physicians of any relevant changes through the *Record*.

BCBSM also maintains a provider appeal process for physician providers. The purpose of the appeal process is to resolve claim or audit disagreements. BCBSM states that most physician complaints regarding a BCBSM policy or practice can be resolved through the provider inquiry department of a field service representative. A matter involving medical policy that cannot be resolved through these channels is referred by BCBSM to its medical policy consultants. Providers may also file appeals alleging that BCBSM has violated specific provisions of Sections 402 and 403 of the Act. Physicians are informed of the appeal process through the *Record.* Information about the appeals process is also included in the *Guide* and in the Physician and Professional Participation Agreement.

BCBSM's current appeal process, as presented in the doctors of osteopathy and medical doctors provider class plans, is described in Attachment B. This appeal process was redesigned in 1994 to be easier, less costly, and quicker to administer while, at the same time, permitting BCBSM to maintain a balance between cost containment and quality care. The appeal process includes a definition of contract issues that can be appealed and, with the establishment of a Physician's Ombudsman office, creates a single focal point within BCBSM for all appeals and disputes. The new process allows non-policy disputes, such as medical necessity determinations, to be settled by arbitration instead of OFIS or the state court system. It also allows for the costs of arbitration to be shared with a $7,500 cap on provider costs. Policy disputes, such as relative value unit assignments, must be settled through the state court system or by OFIS.

Findings and Conclusions - Quality of Care

In order to meet the quality of care goal, the provider class plan must assure that "providers will meet and abide by reasonable standards of health care quality." During calendar years 1998 and 1999, BCBSM continued to monitor the effectiveness of physician utilization management and quality assessment programs and maintained communication with physician providers through its monthly publications, appeal processes and provider manuals. BCBSM also developed initiatives to improve quality of care through demonstrated outcomes and performance standards that will be used as a basis for future quality of care measurements. Based on the information analyzed during this review, it is determined that BCBSM met the quality of care goal stated in the Act for the calendar years 1998 and 1999.

Cost Goal:

The cost goal in Section 504(1) of the Act states that "[P]roviders will be subject to reimbursement arrangements that will assure a rate of change in the total corporation payment per member to each provider class that is not higher than the compound rate of inflation and real economic growth."

After application of the cost formula found in Section 504 of the Act and using economic statistics published by the U. S. Department of Commerce, it is hereby determined that the measure that will be used to determine BCBSM's achievement of the cost goal shall be as follows:

> The rate of change in the total corporation payment per member for the doctors of osteopathy and medical doctors provider classes for calendar years 1998 and 1999 shall not exceed 4.4%.

The pertinent issues that were considered in reaching a determination with respect to the cost goal are described below.

The cost goal formula, as stated in the Act, is

$$\frac{[(100 + I) \times (100 + REG)]}{100} - 100 = \text{Compound rate of inflation and real economic growth}$$

"I" is "inflation" which is the arithmetic average of the percentage change in the implicit price deflator for GNP over the two calendar years immediately preceding the year in which the Commissioner's determination is being made.

"REG" is "real economic growth" which is the arithmetic average of the percentage change in per capita Gross National Product (GNP) in constant dollars over the four calendar years immediately preceding the year in which the Commissioner's determination is being made.

Given the July 2000 population data obtained from population reports (Series P-25) published by the Bureau of Census, as obtained by OFIS from the U. S. Census Bureau (www.census.gov/population/estimates/nation/intfile1-1.txt), and economic statistics for the GNP and implicit GNP price deflator published in the December 2001 edition of "Economic Indicators", prepared for the Joint Economic Committee, by the Council of Economic Advisers (www.access.gpo.gov/congress/eibrowse/broecind.html) the following calculations have been derived:

I = Inflation as defined in the cost goal formula:

	% change in implicit GNP price deflator
1999	1.4
1998	1.2
2 yr. average	1.3

REG = Real Economic Growth as defined in the cost goal formula:

	% change in per capita GNP in constant dollars
1996	2.6
1997	3.4
1998	3.3

1999	3.2
4 yr. average	3.1

Using the latest population and economic statistics available, the cost goal for the period under review is estimated to be 4.4%, as shown below:

Inflation = 1.3

Real Economic Growth = 3.1

$$\frac{[(100 + 1.3) \times (100 + 3.1)]}{100} - 100 = 4.44\%$$

Section 517 of the Act requires BCBSM to transmit an annual report to OFIS, which includes data necessary to determine the compliance or noncompliance with the cost and other statutory goals. The report must be in accordance with forms and instructions prescribed by the Commissioner and must include information as necessary to evaluate the considerations of Section 509(4).

As stated in Section 504(2)(e) of the Act, the "'[R]ate of change in the total corporation payment per member to each provider class' means the arithmetic average of the percentage changes in the corporation payment per member for that provider class over the 2 years immediately preceding the commissioner's determination." The cost and membership data for the doctors of osteopathy and medical doctors provider class plans for the calendar years 1998 and 1999, as filed with OFIS by BCBSM, are presented in Exhibit B. Cost data reflect claims incurred in the calendar year and paid through February 28th of the following year.

The two-year arithmetic average increase for the doctors of osteopathy and medical doctors provider class plans equal 7.0% and 8.0%, respectively. BCBSM was able to limit the average rate of change to the 4.4% cost goal in only six of the ten categories of service for the doctors of osteopathy provider class. BCBSM experienced digit increases in the average payment per member for medical visits, other medical services (e.g. diagnostic services that screen for and diagnosis disease), professional component (the payment made to a physician for reviewing or interpreting tests or films) and consultation services. These services account for nearly one-half of all the services received by BCBSM members during the reporting period and nearly 40% of the overall payout for the doctors of osteopathy provider class.

On the other hand, BCBSM was able to limit the average rate of change to the 4.4% cost goal in only four of the ten categories of service for the medical doctors provider class. Unfortunately, these four categories of service account for only 6% of the services received by BCBSM members during the reporting period and only 8.2% of the overall payout for the medical doctors provider class.

A number of factors affect BCBSM's cost goal performance. Many of these factors are described below:

The average payment per member for medical visits for both provider classes increased 12.6%. This increase likely is the result from the continual shift of patient care from the inpatient setting to the physician office setting. New and improved drug therapies also contribute to a rise in office visits. The proven benefits of treating conditions such as high cholesterol and asthmas with specific drug therapies result in more physician visits in order to monitor the proper dosage, frequency of use, side effects and possible drug interactions. An increase in consumer advertising by pharmaceutical manufacturers also may contribute to the increased number of medical visits as patients seek to find out whether a change in their medication regime may enhance their lifestyles. BCBSM notes that the data shows that its older members are receiving more screening tests and visiting their physicians for preventive care. Although these positive indicators illustrate that the health problems of BCBSM members are being diagnosed sooner, it also helps explain the overall increase in the use of medical visits.

The other medical services category of service includes chemotherapy drugs, allergy testing and injections, nerve conduction testing, pulmonary function testing, and cardiac services such as stress testing, echocardiography, angioplasty, and cardiac catheterization. The double digit increase in the average payment per 1000 members for other medical services for the doctors of osteopathy provider class clearly was the result of an increase in payment per service of 11%, with utilization of such services increasing only 1.5%. Interestingly enough, increases in the average payment per 1000 members for the same category of service for the medical doctors provider class appears to be influenced by an increase in utilization of 8.4%, with increases in payment per service increasing only 3.8%.

The health status of BCBSM members largely contributed to the utilization of these types of medical services. Heart disease and its related effects are among the top health issues in Michigan. Four of the top ten medical services for 1999 for the doctors of osteopathy provider class pertain to the screening and diagnostic testing of heart related conditions. These services, including ECGs, echocardiography and stress tests, account for over 18% of the total services and 20% of the total payments for the other medical service category of service. Similarly, seven of the top ten medical services for 1999 for the medical doctors provider class pertain to the screening and diagnostic testing of heart related conditions. These services, including echocardiography, stress tests, ECGs and cardiac catheterizations, account for over 29% of the services and 26% of the total payments for other medical service category during 1999.

Chemotherapy drugs had a major impact on increases in the average payment per 1000 members for both provider classes. The increased availability of effective cancer fighting drugs has greatly enhanced life span and the quality of life for many cancer patients. Yet, these drugs are quite expensive, with the average payment per service exceeding $1000, as compared to an average payment per service for all other medical services of $53 and $60, for the doctors of osteopathy and medical doctors provider classes, respectively.

Surgical procedures account for over 38% and 28% of the total payout for the doctors of osteopathy and medical doctors provider classes, respectively. Payment per service largely

influenced the overall increase in the average payment per 1000 members, as both provider classes experienced an overall decrease in the utilization of such service. Yet, even though obvious differences in the practice styles of doctors of osteopathy and medical doctors have diminished over recent years, certain types of surgical services are more prominent for one provider class than the other. For example, while acne surgery and destruction of lesions topped the list of the highest total payout of the top 50 surgical procedures for doctors of osteopathy, colonoscopy and cataract procedures topped the list of the highest total payout of the top 50 procedures for medical doctors.

The utilization of basic colonoscopy procedures increased almost 22% over the two-year period under review for the medical doctors provider class. Colonoscopy has become a significant tool in the diagnosis and management of colonic diseases as it is now possible to detect and remove most polyps without the need for abdominal surgery. As a diagnostic tool, colonoscopy may also be more accurate than an x-ray exam of the colon in detecting polyps or cancer. The added bonus that colonoscopy provides that an x-ray exam does not is that polyps can also be removed at the same time.

Acne surgery and the destruction of lesions accounted for over 16% of all surgical procedures for the doctors of osteopathy provider class in 1999. The destruction of lesions was the most highly utilized surgical procedure relating to the skin and subcutaneous system for the medical doctors provider class. BCBSM claims that patient awareness of skin cancer has been beneficial in aiding the prevention of skin cancer, but has also added to the number of lesions being removed unnecessarily. Several destruction procedures were eliminated in 1998 and replaced with new codes and new benefit rules. The benefit rules for most customer groups now impose a specific number of times the procedure can be billed per patient per year. These benefit limitations are designed to control the potential overuse of these types of procedures. BCBSM also put several of the skin lesion destruction procedures on its focused procedure list in 1999 so that it may more easily monitor the utilization trends relating to these procedures.

Another factor affecting the cost and use of physician services is the continual shift of members from traditional benefit programs to managed care products. The number of members enrolled in BCBSM's traditional medical/surgical benefit programs decreased 7.2% from 1998 to 1999. As BCBSM's traditional membership shrinks, the pool of members remaining in the traditional product tend to be older, and on average, less healthy individuals who require a broad range of health services to improve health status.
Michigan residents are still relatively unhealthy compared to the rest of the nation. Although heart disease, cancer deaths, infant mortality, and teen pregnancy have decreased over recent years due to advances in treatment, prevention programs, and increased public education, much still can be done to improve the health of Michigan residents. Promoting and recognizing the benefits of preventive services and diagnostic screening have been the focus of BCBSM's utilization management programs during the two-year reporting period.

Several of the cost trends seen in both physician classes can be attributed to Michigan's high prevalence of smoking, obesity, and sedentary lifestyles. These behaviors contribute to increased services required to manage heart disease, cancer, and other ailments. BCBSM

states that nearly one third of the deaths in Michigan in 1998 were due to heart disease and asserts that the five leading causes of death in Michigan – heart disease, cancer, stroke, chronic obstructive pulmonary disease– accounted for more than 71% of all deaths that year. BCBSM believes that it adequately addressed these issues by implementing initiatives that will work to reduce the prevalence of diseases and accidents.

Medical technology continues to be an important factor in health spending increases. Improved devices, procedures, and drug therapies as well as new applications of existing technology, are helping fight disease, but all these applications increase the overall cost of care. Examples of new medical technology include advances in imaging, minimally invasive surgery with fiber-optic technology, miniaturization of medical instruments and image digitization, gene therapy, and a streamlined FDA approval process for new innovative drugs. Of the 35 new drugs approved by the FDA in 1999, 19 of them were cancer-fighting treatments. BCBSM states that in the absence of clinical guidelines, new technologies undergo rigorous evaluation before they are approved by BCBSM as a new benefit option. In 1999, BCBSM states that it approved 21 new services, nine of which were cancer treatment procedures, four involved bone marrow/stem cell transplantation with the others designed to diagnose and treat procedures for cardiac conditions, women's health issues, neurological disorders and spinal deformities.

Cost is clearly affected by BCBSM's reimbursement methodology for physician services, as presented on page 3 of this report. Physician services are reimbursed the lesser of billed charges or BCBSM's maximum payment levels. Effective April 1, 1999, BCBSM implemented the 1998 HCFA relative value units with a budget neutral conversion factor. Changes in the relative value units impact physician fees. Maximum payment levels for individual procedure codes either increased or decreased based on the new relative value units and conversion factor. The increases in the maximum payment levels for most procedures in 1998 and 1999, were 0.8% and 1.5%, respectively. These payment increases did not apply to the focused procedures described below, as the utilization and billing patterns of such services were determined to be outside normal ranges. BCBSM states that it conducted a comprehensive analysis of physician performance and current economic indicators to calculate the increases. The conversion factor for anesthesia services was adjusted by geographic area where participation rates were lower than in the rest of the state.

BCBSM remains committed to reviewing professional provider performance on an annual basis to determine the need for increases or decreases in the maximum payment levels. Throughout 2000, BCBSM began working with physicians to develop goals for pharmacy and provider utilization patterns. Progress toward these goals will serve as the basis for future fee increases. BCBSM also continued to monitor procedures with high utilization and billing patterns. BCBSM increased the number of procedure codes on its focused procedure list from 82 procedures in 1998 to 125 procedure codes in 1999. The type of procedures BCBSM is monitoring through its focused procedure program include sinus x-rays, hysterectomies, heart image x-rays, arthroscopies of the knee, injection therapy of the veins, somatosensory testing and drainage or injections to the joint/bursa (e.g. fingers, toes).

BCBSM revised its Retrospective Profiling System, described on pages 16 and 17 of this report, during 1999 in an effort to work toward developing practice standards as a measure of quality by providing physicians with disease specific profiles. This change enables physicians to evaluate and improve their individual performances based on appropriate procedures from clinically tested, standard protocols. In 1999, 578 diabetes specific profiles were mailed to physicians. In the long run, BCBSM hopes to influence physician performance that in turn will reduce both the cost and utilization of certain services. BCBSM purchased a software package in 2001 called Diagnostic Cost Groups that will allow BCBSM to measure the severity of illness of a specific patient population. The software is designed for use by HMOs so BCBSM is currently working to adapt it to work with BCBSM's non-HMO business. Once adapted, BCBSM will be able to run a physician's patients' claim data through the software so that it can measure the severity of the physician's patient population and assign it a score. This software will also be able to project what the patient population's severity of illness score will be in one to two years. By measuring a physician's patient population's severity of illness, BCBSM will better be able to compare a physician's utilization with his or her peers, taking into account not just the physician's specialty, but also the physician's patient population. BCBSM notes that because of its need to install a new claims processing system, these new utilization profiles may not be available for a few more years.

During the review of the doctors of osteopathy and medical doctors provider class plans for calendar years 1992 to 1993, the Commissioner reminded BCBSM of its responsibility to exercise responsible cost controls without jeopardizing accessibility and quality of care. BCBSM believes that despite its inability to meet the statutory cost goal, it has implement several programs aimed at controlling cost over the long run. Among these initiatives were the full implementation of the RBRVS system, an expansion of the focused procedure program to monitor procedures with unusually high utilization trends and the ongoing modifications to its provider profiling program.

In addition, BCBSM re-evaluated the feasibility of the Location of Service Differential (LOSD) Program to ensure that it coincided with the RBRVS methodology. BCBSM now plans to revise the LOSD program in 2002. A reimbursement differential will be applied on a procedure specific basis using the Health Care Financing Administration's (HCFA) RBRVS values for facility and non-facility settings for approximately 1,650 procedure codes that HCFA has identified as primarily office-based procedures. This will replace BCBSM's current LOSD program that differentially prices approximately 170 office-based procedures. A budget neutral conversion factor will be applied to all procedure codes, which potentially may affect all physician fees.

Findings and Conclusions - Cost

Based on the cost information analyzed during this review, it is determined that BCBSM did not meet the cost goal stated in the Act for the doctors of osteopathy and medical doctors provider classes during the two year period under review. This decision is based on the fact that the rate of change in the total corporation payment per member for the doctors of osteopathy and medical doctors provider classes has been calculated to be 7.0 % and 8.0%,

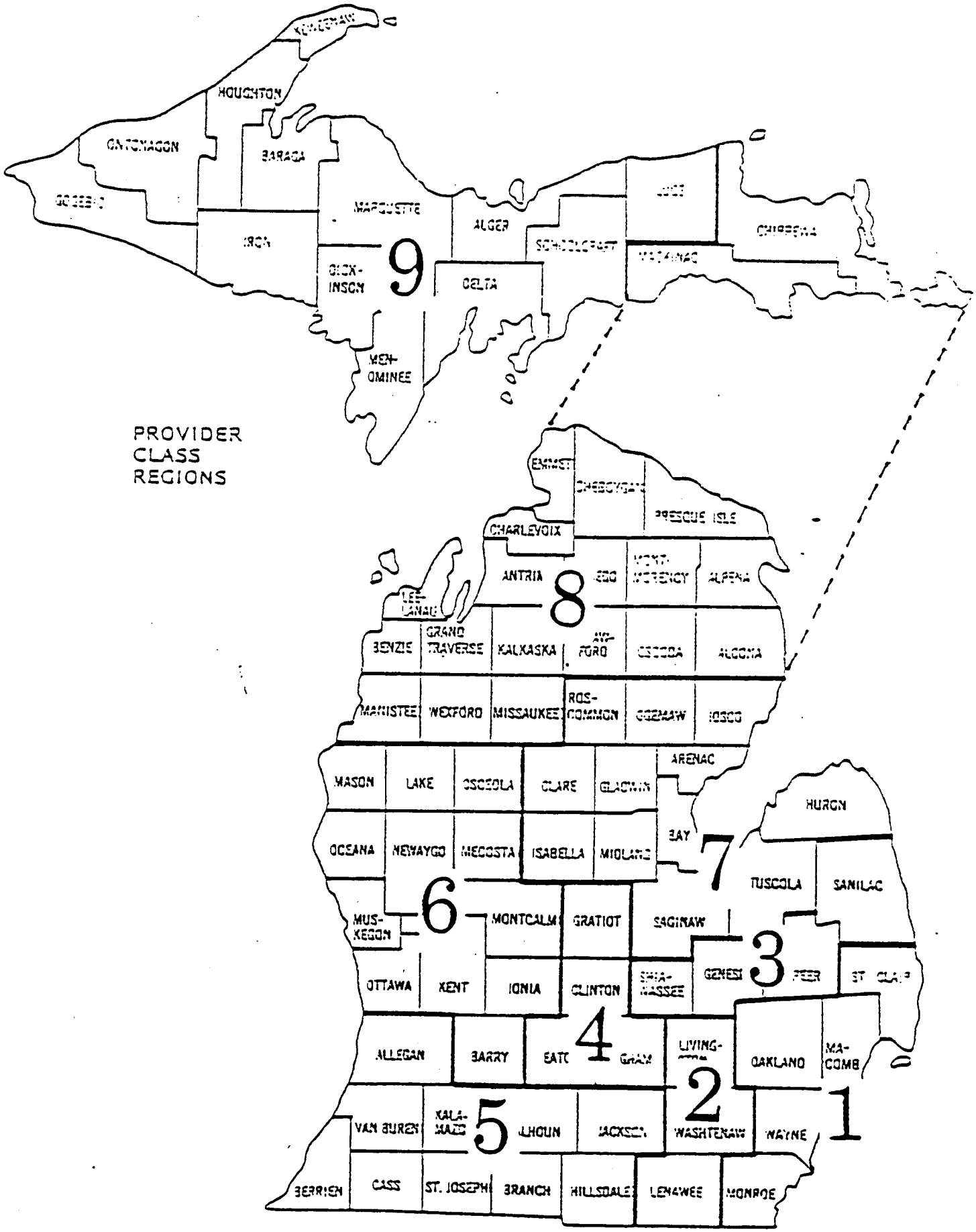
respectively, over the two years being reviewed, and therefore exceeded the compound rate of inflation and real economic growth of 4.4%.

A substantial increase in medical visits as more and more physician services can be safely done on an outpatient basis, an increase in the use of medical diagnostics, the lifestyle choices of BCBSM members and national health trends all impact the cost and use of BCBSM covered physician services. All of these factors, described within this section on BCBSM's cost goal achievement, account for increases in the cost and use of doctors of osteopathy and medical doctors' services. BCBSM has demonstrated that it continues to pursue new innovative programs in attempt to control costs, inappropriate use and over-utilization of services. For example, BCBSM adopted quality goals for 2000 based upon the federal government's *Healthy People 2010* initiative. BCBSM believes that education and collaboration with physicians will continue to be a key strategy in order to identify opportunities for efficiency while promoting best practices based on evidence-based medicine. BCBSM's hiring of a consultant to study, analyze and issue the Dartmouth Atlas of Health Care in Michigan report also increased BCBSM's ability to gain a better understanding of the variation in the use of health care services throughout the state and enables BCBSM to work with communities to enhance the quality of health care. BCBSM expects to continue working collaboratively with physicians, hospitals, employers, labor unions and consumers in this ongoing effort.

Because of this, it is not necessary to require a change to the current doctors of osteopathy and medical doctors provider class plans be filed pursuant to Section 511. BCBSM is encouraged to continue its efforts to find new, innovative programs that instill responsible cost controls so that all the goals and objectives of the corporation can be achieved.

Determination Summary

In summary, BCBSM achieved two of the three goals of the corporation during the two-year period under review for the doctors of osteopathy and medical doctors provider class. Although the doctors of osteopathy and medical doctors provider class plans did not substantially achieve the cost goal, a change in these plans is not required because, as concluded on page 28 of this determination report, there has been competent, material, and substantial information obtained or submitted to support a determination that the failure to achieve the cost goal was reasonable, due to factors listed in Section 509(4).


PROVIDER
CLASS
REGIONS
HOUGHTON
GOGEBIC
BARAGA
IRON
MARQUETTE
ALGER
DICK-
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DELTA
MEN-
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CHARLEVOIX
ANTRIM
LEE-
LANAU
BENZIE
GRAND
TRAVERSE
KALKASKA
OSCEOLA
ALCONA
MANISTEE
WEXFORD
MISSAUKEE
ROS-
COMMON
GLADWIN
IOSCO
ARENAC
MASON
LAKE
OSCEOLA
CLARE
OCEANA
NEWAYGO
MECOSTA
ISABELLA
BAY
HURON
TUSCOLA
SANILAC
MUS-
KEGON
MONTCALM
GRATIOT
SAGINAW
OTTAWA
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CLINTON
SHIA-
WASSEE
GENESEE
ALLEGAN
BARRY
OAKLAND
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VAN BUREN
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ATTACHMENT B

BLUE CROSS BLUE SHIELD OF MICHIGAN
PROVIDER APPEAL MECHANISMS
PERTAINING TO THE DOCTORS OF OSTEOPATHY
AND MEDICAL DOCTORS PROVIDER CLASSES

Concerns regarding BCBSM policy may be submitted in writing to BCBSM's Physician's Ombudsman Department. A response will be issued in writing within 30 days of the request. If a physician is dissatisfied with BCBSM's response, the physician may request a review by the BCBSM Medical Director within 30 days of BCBSM's initial response. BCBSM's final response on the matter will be issued within 30 days. The issue and its disposition will be reported to the Physician Contract Advisory Committee(s) for information purposes.

BCBSM's appeals process includes three potential forums for dispute resolution and is intended to resolve disputed matters quickly and inexpensively. Steps 1 and 2 of the appeal process satisfy the administrative procedure outlined in the Act. Please note that an election must be made at the conclusion of Step 2 (BCBSM's Post-Conference Statement) regarding binding arbitration, OFIS Review or judicial review of the dispute. Once the physician elects one of these three methods for final resolution of the dispute, the remaining two remedies and procedures are deemed waived for that particular dispute. The physician has the right to appoint another person to act as his/her agent or representative in any of the steps of an appeal.

Disputes may be appealed to the OFIS or court action may be initiated. Binding arbitration is available for some types of disputes. Non-policy disputes may be arbitrated. Non-policy issues include by way of example: a) medical necessity determinations; b) claims denials under the pre-existing condition exclusion in member's agreements; c) pre-certification program rejections relating to length of stay or appropriateness of treatment setting; and, d) audit recovery demands involving requests for repayment of monies related to testing or x-rays unsupported by the documented medical record.

The arbitration option is not available for policy related disputes. Policy related issues include by way of example: a) RVU assignments or conversion factors, both of which affect BCBSM's price per procedure; b) sanctions in cost containment programs such as the failure to obtain a second surgical opinion for a coronary bypass procedure; c) multiple surgery rules such as the full and half payment rule; d) experimental or investigational benefit exclusions; e) departicipation decisions; and, f) audit methodologies, such as the use of statistical sampling for audit refund projections.

APPEAL PROCESS STEPS

After the physician has completed BCBSM's normal status inquiry, telephone and written inquiry procedures, the physician shall begin the appeals process by submitting a written complaint to BCBSM regarding the nature of any unresolved areas of the dispute. BCBSM shall, within 30 days, provide in writing a clear, concise and specific explanation of all of the reasons for its action that addresses the physician's complaint.

If the physician does not agree with BCBSM's explanation, the physician may request a managerial-level conference within 60 days of receipt of BCBSM's written explanation. The notice should be sent to BCBSM's Physician's Ombudsman Department. BCBSM will schedule the informal conference within 30 days of receipt of the provider's request. At the request of the physician, the conference may be held by telephone. The purpose of the informal conference is to discuss the dispute in an informal setting and explore possible resolution of that dispute. If the dispute involves matters of a medical nature, a BCBSM consulting physician will participate in the conference. If the dispute is non-medical in nature, other appropriate BCBSM employee(s) will attend.

Within 10 days following the conclusion of the informal conference, BCBSM shall provide all of the following to the physician: a) the proposed resolution; b) the facts, with supporting documentation, on which the proposed resolution is based; c) the specific section or sections of the Act, certificate, contract or other written policy or document on which the proposed resolution is based; (d) a statement explaining the physician's right to appeal the matter within 30 days after receipt of BCBSM's written statement; and, (e) a statement describing the status of each claim involved.

Within 30 days after receipt of BCBSM's post conference statement, the physician shall have the right to appeal BCBSM's proposed resolution either by submitting a Demand for Arbitration to BCBSM or by submitting a request to OFIS for a review and determination. The physician shall also have the option of initiating litigation in the appropriate court. The physician's election to pursue binding arbitration is a waiver of any and all other remedies or procedures for resolution of the dispute. Similarly, notice of the physician's election to request that OFIS conduct a review and determination or the election to litigate the dispute waives any right to submit the dispute to binding arbitration under this Agreement.

Binding arbitration of the physician's dispute is an alternative to judicial review in any appropriate court of law or to an administrative review by OFIS under Part 4 of the Act.

Requests for arbitration should be sent to BCBSM's Physician Arbitration Department. A judgment of any circuit court may be rendered upon an arbitration award made in this type of dispute.

Alternatively, the physician may elect to have the dispute reviewed by OFIS under Part 4 of the Act. The physician may initiate an informal review and determination of the dispute by submitting a written complaint to OFIS within 120 days of receipt of BCBSM's determination and should specify which provisions of Sections 402(1) and 403 of the Act that BCBSM has violated. The informal review and determination may take place through submission of written position papers or through the scheduling of an informal meeting at the offices of OFIS. OFIS shall issue its determination within 10 days of the receipt of position papers requested of the parties.

If dissatisfied with the review and determination by OFIS, either the physician or BCBSM may ask the Commissioner to hear the matter as a contested case under the Michigan Administrative Procedures Act. A contested case must be requested in writing within 60 days after the review and determination is issued. Either the physician or BCBSM may appeal the contested case result to the Ingham County Circuit Court.

DOCTORS OF OSTEOPATHY AND MEDICAL DOCTORS
SERVICE BENEFIT LEVEL RATES BY SPECIALTY - 1999

Specialty	Reg 1 Rate	Reg 2 Rate	Reg 3 Rate	Reg 4 Rate	Reg 5 Rate	Reg 6 Rate	Reg 7 Rate	Reg 8 Rate	Reg 9 Rate
General Practice	96.5%	96.0%	92.6%	90.9%	91.2%	91.9%	97.3%	96.8%	98.1%
General Surgery	97.0%	97.4%	86.0%	100.0%	94.4%	96.4%	97.1%	95.8%	100.0%
Allergy	**93.8%**	**100.0%**	**100.0%**	**100.0%**	**81.8%**	**80.0%**	**85.7%**	**100.0%**	**100.0%**
Otorhinolaryngology	**93.5%**	**89.7%**	**90.9%**	**80.0%**	**50.0%**	**74.1%**	**66.7%**	**50.0%**	**75.0%**
Anesthesiology	**92.7%**	**98.9%**	**98.0%**	**65.4%**	**96.4%**	**91.8%**	**94.7%**	**90.7%**	**100.0%**
Cardiovascular	99.7%	100.0%	100.0%	97.4%	100.0%	100.0%	100.0%	100.0%	100.0%
Dermatology	96.4%	93.1%	100.0%	71.4%	73.7%	43.8%	71.4%	75.0%	100.0%
Family Practice	96.9%	96.6%	98.9%	98.0%	89.9%	92.6%	93.4%	98.7%	100.0%
Gynecology	83.3%	66.7%	0.0%	100.0%	90.9%	60.0%	100.0%	100.0%	100.0%
Gastroenterology	98.2%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Internal Medicine	97.0%	96.5%	99.0%	96.4%	94.2%	92.0%	98.4%	100.0%	95.8%
Manipulative Therapy	100.0%	---	---	60.0%	---	100.0%	---	0.0%	---
Neurology	98.9%	90.2%	84.6%	100.0%	96.6%	78.3%	100.0%	100.0%	100.0%
Neurological Surgery	**98.7%**	**73.3%**	**100.0%**	**100.0%**	**66.7%**	**66.7%**	**100.0%**	**42.9%**	**100.0%**
OB-Gynecology	95.5%	98.0%	98.5%	100.0%	87.2%	91.2%	100.0%	100.0%	96.2%
Ophthal/Otorhino	100.0%	---	80.0%	---	---	100.0%	100.0%	100.0%	---
Ophthalmology	**91.2%**	**62.3%**	**88.0%**	**85.7%**	**98.2%**	**80.4%**	**93.8%**	**91.3%**	**91.7%**
Orthopedic Surgery	**96.8%**	**81.0%**	**82.1%**	**66.7%**	**79.0%**	**52.3%**	**89.5%**	**100.0%**	**90.5%**
Pathologic Anatomy	96.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Pathology	97.2%	95.8%	89.5%	91.3%	100.0%	95.2%	100.0%	100.0%	100.0%
Plastic Surgery	**64.1%**	**86.7%**	**75.0%**	**77.8%**	**15.4%**	**87.0%**	**87.5%**	**0.0%**	**100.0%**
Physical Med & Rehab	98.7%	92.9%	100.0%	100.0%	86.7%	76.2%	100.0%	100.0%	100.0%
Psychiatry	85.9%	77.3%	95.5%	86.6%	88.3%	83.9%	96.2%	87.2%	88.0%
Psychiatry, Neurology	89.5%	100.0%	100.0%	100.0%	100.0%	50.0%	100.0%	66.7%	---
Proctology	100.0%	---	---	100.0%	100.0%	100.0%	100.0%	---	---
Pulmonary Diseases	99.0%	100.0%	91.7%	100.0%	88.9%	88.9%	100.0%	100.0%	100.0%
Radiology	98.6%	97.8%	98.1%	100.0%	90.5%	89.9%	100.0%	100.0%	100.0%
Roentgenology/Radiology	100.0%	100.0%	100.0%	100.0%	87.5%	100.0%	100.0%	100.0%	85.7%
Radiation Therapy	100.0%	100.0%	100.0%	---	83.3%	100.0%	100.0%	100.0%	---
Thoracic Surgery	98.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	50.0%	100.0%
Urology	**98.1%**	**97.3%**	**54.5%**	**58.3%**	**78.3%**	**75.0%**	**80.0%**	**63.6%**	**100.0%**
Pediatrics	97.0%	94.3%	100.0%	94.3%	96.3%	88.4%	98.6%	97.4%	95.7%
Preventive Med	88.9%	---	50.0%	100.0%	100.0%	66.7%	100.0%	100.0%	75.0%
Infectious Disease	98.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Total	95.8%	93.7%	95.4%	91.9%	90.9%	88.7%	95.9%	94.8%	96.8%

--- No providers or claims in the region

Specialties in bold cited by OFIS as having low participation rates in 1996

Doctors of Osteopathy

Type of Service	Avg Pay/ 1000	Avg Serv/ 1000	Avg Pay/ Serv	3 Year Payments	% of Payments	3 Year Services	% of Services
Surgery	3.8%	-4.3%	8.6%	$56,838,756	38.4%	479,349	18.6%
Medical Visits	12.6%	5.6%	6.6%	$32,174,895	21.8%	816,972	31.6%
Other Medical Services	12.8%	1.5%	11.0%	$18,419,893	12.5%	391,286	15.2%
Diagnostic Radiology	3.7%	-2.3%	6.1%	$13,102,242	8.9%	218,819	8.5%
Professional Component	14.9%	14.0%	0.9%	$3,499,101	2.4%	7,548	0.3%
Anesthesia	1.8%	-4.9%	7.1%	$3,110,180	2.1%	35,918	1.4%
Maternity	0.2%	2.2%	-2.0%	$4,314,056	2.9%	85,256	3.3%
Consultation	10.7%	6.2%	4.2%	$3,977,877	2.7%	46,705	1.8%
Psych Care/Sub Abuse	3.6%	3.4%	0.2%	$3,846,953	2.6%	17,590	0.7%
Physical Therapy	-2.2%	-21.4%	26.5%	$2,952,486	2.0%	81,241	3.1%
All Others	2.9%	-4.0%	21.7%	$5,676,797	3.8%	401,694	15.6%
Total	7.0%	0.1%	6.9%	$147,913,236	100.0%	2,582,378	100.0%

Medical Doctors

Type of Service	Avg Pay/ 1000	Avg Serv/ 1000	Avg Pay/ Serv	3 Year Payments	% of Payments	3 Year Services	% of Services
Surgery	4.7%	-0.1%	4.8%	$496,274,707	28.4%	3,131,083	11.9%
Medical Visits	12.6%	8.4%	3.8%	$350,687,738	20.0%	7,504,204	28.4%
Other Medical Services	13.5%	6.4%	6.7%	$249,907,391	14.3%	4,199,358	15.9%
Diagnostic Radiology	10.1%	4.5%	5.4%	$176,109,403	10.1%	1,869,693	7.1%
Professional Component	5.1%	3.6%	1.4%	$168,212,301	9.6%	4,302,482	16.3%
Anesthesia	4.9%	3.6%	1.3%	$92,223,469	5.3%	361,257	1.4%
Maternity	0.5%	-2.3%	2.9%	$62,930,747	3.6%	122,268	0.5%
Consultation	10.6%	5.6%	4.8%	$47,979,877	2.7%	414,132	1.6%
Psych Care/Sub Abuse	1.8%	0.4%	1.5%	$28,709,014	1.6%	397,673	1.5%
Laboratory/RIA	7.1%	-0.4%	7.5%	$23,558,674	1.4%	3,055,321	11.6%
All Others	2.9%	12.4%	-8.6%	$53,264,193	3.0%	1,043,079	4.0%
Total	8.0%	4.8%	3.0%	$1,749,857,514	100.0%	26,400,550	100.0%